

Medical Services

Nonphysician Health Care Providers

**Headquarters
Department of the Army
Washington, DC
7 November 2000**

UNCLASSIFIED

SUMMARY of CHANGE

AR 40-48

Nonphysician Health Care Providers

This revision--

- o Revises chapter 2 of the 1 August 1995 edition of AR 40-48. Changes made to chapter 2 apply only to the practice and supervision of certified registered nurse anesthetists. This revision--

--In the summary of change, in the bullet paragraph beginning "Establishes....," deletes the term "certified registered nurse anesthetists."

--In paragraph 2-1, in the paragraph beginning "Prior to....," supersedes the phrase "in a through d below."

--In paragraph 2-1d, supersedes the sentence beginning "The specific..." and adds a note and paragraphs 2-1d(1) through 2-1d(8).

--In paragraph 2-2, in the paragraph beginning "Army Nurse Corps....," deletes "CRNAs."

--In paragraph 2-2, rescinds paragraph 2-2b and re-alphabetizes the remaining paragraphs in paragraph 2-2. In the paragraph beginning "Authentication of," deletes "CRNAs."

--In paragraph 2-2g and appendix A, removes reference to obsolete AR 600-6.

--In paragraph 2-3, supersedes paragraph 2-3c, deleting the sentence beginning "CRNAs have...."

--Adds the acronym "ASA" to the glossary, section I.

--Adds the term "ASA categories I-V" to the glossary, section II.

--Replaces references to obsolete DA Form 67-8 with DA Form 67-9 (Officer Evaluation Report).

--Replaces references to obsolete SF 522 with OF 522 (Medical Record--Request for Administration of Anesthesia and for Performance of Operations and Other Procedures.

--Replaces references to obsolete SF 517 with DA Form 7389 (Medical Record--Anesthesia).

- o Eliminates the requirement that medical treatment facility commanders request approval from the Office of The Surgeon General as an exception to policy to use civilian nurse practitioners (chap 2).

- o Establishes authority for local review and approval of all prescription writing by nurse practitioners, certified nurse midwives, community health nurses, and physician assistants (paras 2-2 and 3-2).
- o Deletes specific listing of medication categories for physician assistant prescriptions and allows local determination of prescription writing authority (chap 3).
- o Includes a requirement for physician assistants to have current National Commission on Certification of Physician Assistants certification (para 3-1a).
- o Adds the statement that physician assistants may be privileged to provide care to all categories of eligible beneficiaries (para 3-2).
- o Addresses specialty program providers (chap 7).
- o Deletes dental hygienists and enlisted medical corpsmen and corpswomen in the Automated Military Outpatient System (formerly chap 9).

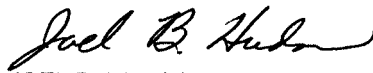
Medical Services

Nonphysician Health Care Providers

By Order of the Secretary of the Army:

ERIC K. SHINSEKI
General, United States Army
Chief of Staff

Official:


JOEL B. HUDSON
Administrative Assistant to the
Secretary of the Army

History. This publication is a revision of this regulation. Because the publication has been extensively revised, the changed portions have not been highlighted.

Summary. This regulation addresses nonphysician health care providers who receive clinical privileges and includes those functioning as both dependent and independent practitioners. This revision

updates the policy on privileging, duties, expanded role functions, and supervision.

Applicability. This regulation applies to the Active Army, the Army National Guard, and the U.S. Army Reserve. It also applies to medical department activities, medical centers, dental activities, and organizations for which the Army Medical Department is the executive agent. This publication is applicable during mobilization.

Proponent and exception authority. The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions to this regulation that are consistent with controlling law and regulation. Proponents may delegate the approval authority, in writing, to a division chief under their supervision within the proponent agency in the grade of colonel or the civilian equivalent.

Army management control process. This regulation contains management control provisions according to AR 11–2, but does not contain checklists for assessing

management controls. Alternative management control reviews are used to accomplish assessment of management controls.

Supplementation. Supplementing this regulation is prohibited without prior approval from HQDA (SGPS–CP), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Suggested Improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (SGPS–CP) 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Distribution. Distribution of this publication is made in accordance with the requirements of DA Form 12–09–E, block number 2061, intended for command level B for Active Army, Army National Guard, and U.S. Army Reserve.

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Chapter 1

Introduction

1–1. Purpose

This regulation establishes policies concerning privileges, duties, expanded roles, and supervision of nonphysician health care providers (HCPs) (military and civilian).

1–2. References

Required and related publications and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Responsibilities

- a.* The Surgeon General (TSG) will—
 - (1) Establish policy concerning the delivery of health care.
 - (2) Establish policy concerning credentials, privileging, duties, and roles of nonphysician HCPs.
- b.* The U.S. Army Medical Command (MEDCOM) commander will—
 - (1) Administer the policies of this regulation.
 - (2) Approve certain nonphysician HCP appointments and placements.
- c.* The medical treatment facility (MTF) commander will—
 - (1) Ensure that the duties, responsibilities, and scope of clinical practice for each professional discipline are documented as noted in the following chapters.
 - (2) Approve the granting of clinical privileges to designated nonphysician HCPs.
 - (3) Appoint a physician supervisor for designated nonphysician HCPs.
 - (4) Ensure the effectiveness of the nonphysician HCP supervision and review process.
 - (5) Approve specific medications for which designated nonphysician HCPs may write prescriptions.
 - (6) Define the scope and limits of clinical practice for certain assigned nonphysician HCPs.

Chapter 2

Nurse Practitioners, Certified Nurse Midwives, Community Health Nurses, and Certified Registered Nurse Anesthetists

2–1. Privileges

Prior to applying for clinical privileges, each nurse practitioner (NP), certified nurse midwife (CNM), community health nurse (CHN), and certified registered nurse anesthetist (CRNA) will meet the criteria for his/her clinical specialty as listed by definition in Section II, Terms. The policies and procedures for credentials review and clinical privileging will be consistent with AR 40–68. The individual's completed application and practitioner credentials file (PCF) will be submitted to the chief nurse (CN) for review, concurrence, and signature prior to being forwarded to the credentials committee. The credentials committee will recommend and the MTF commander will approve clinical privileges that are based on pre-established practice protocols/clinical practice guidelines (CPGs) discussed in *a* through *c* below. (See AR 40–68 for detailed privileging guidance and information on credentials committees.)

a. Nurse practitioner. The NP and designated physician supervisor will establish mutually agreed upon practice protocols/CPGs. These practice protocols/CPGs will be signed by the supervising physician, the NP, the chief of the medical department or service in which the NP practices, and the CN. Questions about the appropriateness of either a protocol or scope of practice will be resolved jointly by the physician specialty consultant to TSG and the appropriate nursing consultant to TSG. Drugs approved for prescription writing will be included as part of the recommended clinical privileges. Practice protocols/CPGs will be reviewed annually and updated as necessary. The credentials of all NPs (for example, active duty nurses, Federal civil service or contract civilian nurses, and Reserve Component nurses) will be reviewed by both the CN and the credentials committee, prior to submission for the commander's approval.

b. Certified nurse midwife. The CNM and the designated physician supervisor will establish mutually agreed upon practice protocols/CPGs. These practice protocols/CPGs must meet the scope of practice parameters of the American College of Nurse Midwives. They will be signed by the supervising physician; the individual CNM; the chiefs of nurse midwifery, obstetrics and gynecology and pediatrics; and the CN. Drugs approved for prescription writing will be included as part of the recommended clinical privileges. Practice protocols/CPGs will be reviewed annually and updated as necessary.

c. Community health nurse. The CHN and the designated physician supervisor will establish mutually agreed upon practice protocols/CPGs. These practice protocols/CPGs will be signed by the supervising physician, the individual

CHN, the chiefs of community health nursing and preventive medicine, and the CN. Drugs approved for prescription writing will be included as part of the recommended clinical privileges. Practice protocols/CPGs will be reviewed annually and updated as necessary.

d. Certified registered nurse anesthetist.

Note. The use of “MTF” in this paragraph applies to both the table-of-distribution-and-allowances and table-of-organization-and-equipment settings.

(1) CRNAs will be responsible and privileged for all the necessary components of anesthesia care they provide for all patients regardless of American Society of Anesthesiologists (ASA) category. The CRNA will—

(a) Establish an anesthesia plan and, based on the preanesthetic assessment, the CRNA will determine that the patient is an appropriate candidate to undergo the planned anesthetic.

(b) Obtain informed consent for anesthetic services.

(c) Select, prescribe, or administer medications and treatment modalities related to the perianesthetic care of patients.

(d) Conduct the assessment immediately before induction to assess the readiness to enter the surgical environment before committing to the anesthetic by its administration.

(e) Select, obtain, and administer anesthetics, adjunct drugs, accessory drugs, and fluids necessary to manage the patient in the perianesthetic period, to maintain the patient’s physiologic homeostasis, and to correct responses to the anesthesia or surgery consistent with the spectrum of anesthesia privileges.

(f) Ensure that the patient’s postoperative status is assessed on admission to and discharge from postanesthesia recovery.

(g) Release or discharge patients from the postanesthesia care area.

(h) Order and initiate perioperative pain relief therapy.

(2) CRNAs are not routinely supervised for ASA category I and category II patients. CRNAs are expected to regularly seek consultations as needed for the safe delivery of the anesthetic or for complicating or unexpected changes in the patient’s medical condition. Ultimate clinical authority and the responsibility (when authority is exercised) for anesthesia services provided for all classes of patients will rest with the assigned anesthesiologist (or senior Medical Corps officer in the chain of command in the absence of an anesthesiologist) as directed by the MTF commander.

(3) For patients in ASA category III, IV, or V, collaboration is required with a physician or oral surgeon before anesthesia care is provided and when indicated for the post-op release from the postanesthesia care unit. This collaboration will be with an anesthesiologist, if available. The CRNA, the physician, or oral surgeon will document the results of this collaboration in the medical record. In the unusual circumstance that a consensus concerning a clinical issue cannot be obtained between a CRNA and an anesthesiologist or attending physician, the ultimate clinical authority and responsibility for anesthesia services provided for all these classes of patients will rest with the assigned anesthesiologist or the attending surgeon if an anesthesiologist is not available.

(4) In an MTF without an assigned or available anesthesiologist, where the surgical team desires to provide care for an ASA III or greater patient, there must be documented collaboration between the CRNA and the surgeon prior to the start of the case.

(5) At MTFs without an assigned anesthesiologist, the MTF commander and supporting Regional Medical Command commander will take steps to ensure that distant oversight is provided by a specific anesthesia consultant for those CRNAs practicing at those MTFs. The commanders will ensure appropriate periodic review by a Regional Medical Command assigned team. The team will be comprised of a senior anesthesiologist and a senior CRNA. The team will validate the clinical performance of the CRNAs to be reviewed.

(6) Generally, an anesthesiologist will be responsible for the overall administrative supervision of an MTF anesthesia program/service. If a qualified anesthesiologist is not available, then the MTF commander may select a more qualified officer to serve in this function at his/her discretion. Inherent in this policy is the expectation that both the anesthesiologists and CRNAs will be assigned to the same department.

(7) When the officer selected to be the Service or Department Chief is a CRNA, an anesthesiologist (if an anesthesiologist is assigned) will be selected as the Medical Director. In those MTFs where there is no assigned anesthesiologist, the Medical Director will be a senior Medical Corps officer. Rating schemes will reflect the administrative command and control regardless of the Corps of the Service/Department Chief. Rating schemes for CRNAs will be developed and evaluations made, with a letter of input to the rater and/or senior rater, on their clinical performance from the assigned or appointed anesthesiologist or senior MC officer if no anesthesiologist is assigned. Anesthesiologists will have an MC as rater or senior rater in their chain of command.

(8) Commanders are charged to ensure that an optimal professional relationship exists in all facilities. A team approach to anesthesia services will facilitate efforts and maximize the quality of health care provided.

2-2. Expanded roles

Army Nurse Corps (AN) officers and civilian registered nurses who function in expanded roles and clinical specialty areas (for example, NPs, CNMs, or CHNs) must be prepared through relevant education and experience. Their

performance will be routinely evaluated to document current competence and identify the knowledge, skills, and behaviors needed to maintain and improve the care provided.

a. Prescription writing. Those nurses who are privileged may write prescriptions for selected medications that have been recommended by the pharmacy and therapeutics (P&T) committee, reviewed by the credentials committee, and approved by the MTF commander. (See AR 40–2 for information on the establishment, composition, and functions of the P&T committee.) All prescriptions will bear the typed, stamped, or printed statement: “May be filled at any military health services system (MHSS) pharmacy that recognizes the provider’s privileges.”

b. Medical examination authentication. NPs, CNMs, and CHNs assigned and utilized in expanded roles will—

(1) Sign in item 79 of the SF 88 (Report of Medical Examination) on routine medical examinations they actually perform. The supervising physician is responsible for the examination and will countersign in item 80 of the SF 88.

(2) Sign the SF 93 (Report of Medical History) in the “Remarks” section in those instances when the SF 93 is required with a routine medical examination.

c. Diagnosis and treatment limitations. NPs, CNMs, and CHNs will not establish a diagnosis or institute any treatment based on telephonic conversations with patients or any nonphysician HCP (unless authorized to do so by approved protocols).

d. Personnel Reliability Program (Nuclear Surety). NPs and CHNs may be authorized to screen health records (HRECs) of individuals who are in or candidates for the Personnel Reliability Program (PRP), according to AR 50–5.

e. Medical support to confinement correctional facilities.

(1) CHNs may assist in weekly preventive medicine inspections of confinement facilities.

(2) NPs may assist in the medical examination and treatment of prisoners in confinement. (See AR 190–47.)

f. Profiles. NPs and CNMs may authorize temporary profiles within the parameters of their specialties except for personnel (other than pregnant personnel) on flight status. Obstetrical/ gynecological (OB/GYN) NPs and CNMs may write and sign temporary profiles for pregnant personnel on flight status. These profiles will not exceed 30 days or remove duty limitations. Those conditions that require a temporary profile for more than 30 days or remove duty limitations, and those conditions that require an extension beyond 30 days must be authenticated by a physician (AR 40–501). OB/GYN NPs and CNMs may write and sign routine or standard pregnancy profiles for the duration of the pregnancy.

g. Quarters. NPs and CNMs may place patients for whom they are providing care on quarters status.

h. Authentication of medical record entries. NPs, CNMs, and CHNs will sign all entries made in medical records according to AR 40–66, chapter 8 and AR 40–407.

i. Diagnostic tests. Nursing personnel who function in expanded roles may request diagnostic tests (for example, radiographs, electrocardiograms, laboratory) consistent with their individual privileges as recommended by the credentials committee and approved by the MTF commander. Appropriate specialists will be consulted as indicated by patient assessment and according to approved protocols.

2–3. Supervisory personnel

The following guidance is provided for supervisors of nursing personnel who function in expanded roles.

a. General. NPs, CNMs, and CRNAs are responsible to the CN for the quality and appropriateness of nursing activities. Medical supervision will be provided by the appointed physician supervisor. The chief of the medical department or service is responsible for the quality and appropriateness of medical care.

b. Community health nurse. CHNs assigned to a U.S. Army Medical Department Activity (MEDDAC) or U.S. Army Medical Center (MEDCEN) preventive medicine service are responsible to the chief, community health nursing service and chief, preventive medicine service. The chief, community health nursing service is responsible to the CN for administrative matters and professional nursing concerns. Medical supervision and direction will be provided by an appointed physician supervisor. A CHN who provides care to several defined patient populations may have more than one appointed physician supervisor. The specific medical supervisors will be dictated by the specialty of the patient population involved (for example, chief, pediatric service for well child physical assessment; chief, pulmonary disease service or appropriate medical specialty for the Tuberculosis Chemoprophylaxis Program).

c. Physician supervisor. The MTF commander will appoint (by name and in writing) a supervising physician for each NP, CNM, and CHN. An alternate supervising physician must be available during temporary absences of the supervising physician. The supervisor must be available for consultation in person or telephonically. The MTF commander will ensure the effectiveness of the supervision and review process.

(1) *Qualifications and duties.* The physician supervisor will—

(a) Be privileged to perform any treatment or procedure that he or she directs a nonphysician HCP to perform.

(b) Be a military physician of the same specialty or a family practice physician for adult or OB/GYN NPs. When a military physician of the same specialty is not available to act as supervisor, the MTF commander will appoint a civilian physician of that same specialty. When a physician of the same specialty is not available to act as supervisor, the MTF commander will appoint another physician and request an exception to policy that will be forwarded through channels for review and approval to Commander, U.S. Army Medical Command, ATTN: MCHO–CL–L, Fort Sam Houston, TX 78234–6000.

(c) Ensure the care provided by the NPs, CNMs, CHNs, and CRNAs remains consistent with their respective scopes of practice and, for NPs, CNMs, and CHNs, within their approved protocols/CPGs.

(2) *Performance evaluations.* The supervising physician may provide written performance evaluations using the DA Form 5441–R series (Evaluation of Privileges—(Specialty)) and DA Form 5374–R (Performance Assessment) that document current competence of the individual’s—

(a) Diagnostic techniques and procedures.

(b) Therapeutic practices/process of care.

(c) Patient treatment documentation based on a review of patient records. The number of records to be reviewed will be determined by the supervising physician based on (a) and (b) above and the quality of the entries.

(3) *Frequency of performance evaluations.* The supervising physician ensures that—

(a) Performance evaluations are conducted periodically based on the individual’s experience and competence and according to local quality improvement (QI) policy and AR 40–68.

(b) In an emergency care center where patients are triaged for potentially life threatening problems, the NP reviews the patient’s plan of care with a physician in accordance with departmental QI policy prior to the patient’s discharge. In an emergency care center where patients are triaged for nonurgent problems to areas such as an “acute minor illness clinic” or “fast track,” NPs may evaluate, treat, and discharge patients independently in accordance with departmental QI policy.

(c) A copy of all written performance evaluations (with the exception of DA Form 67–9 (Officer Evaluation Report)) is forwarded to the MTF credentials committee. These documents will be maintained according to AR 40–68 and will be part of the basis for renewing/revising clinical privileges.

Chapter 3

Physician Assistants

3–1. Privileges

a. All physician assistants (PAs) must have current National Commission on Certification of Physician Assistants (NCCPA) (or its successor) certification before they can be granted clinical privileges. New Department of Defense (DOD)-trained PAs can be granted and maintained on provisional privilege status until they pass the NCCPA examination.

b. The appropriate level table of organization and equipment (TOE) surgeon will participate in the privileging process for PAs assigned to TOE units.

c. The MTF commander, upon recommendation from the credentials committee, can grant clinical privileges to civilian PAs supervised by a Civilian Health and Medical Program of the Uniformed Services, Primary Care for the Uniformed Services, or partnership physician. However, privileges granted cannot exceed privileges permitted under applicable State law and/or regulation.

3–2. Duties and responsibilities

PAs are a primary source of medical care for all categories of beneficiaries.

a. *Outpatient duties.* PAs outpatient duties include—

(1) *General medical care.* PAs provide—within their limits of training and privileges—primary and specialty medical care for the sick and wounded.

(2) *Diagnosis, treatment, and prescription.* Appropriately privileged PAs may diagnose, prescribe for, and treat diseases, disorders, and injuries.

(3) *Returning patients.* PAs must consult with a physician when a patient presents with the same unresolved complaint twice in a single episode of care. Physician consultation will be documented on either an SF 600 (Health Record—Chronological Record of Medical Care) or an SF 513 (Medical Record—Consultation Sheet). This does not apply to patients returning for routine (or directed) follow-ups or treatment of chronic illnesses previously documented in their medical records.

(4) *Diagnosis and treatment limitations.* PAs will not make a diagnosis or institute any treatment based on telephonic conversations with patients unless authorized by physician-approved protocols.

(5) *Referral and evacuation.* Situations requiring more highly skilled medical diagnosis and treatment will be referred or evacuated. In the absence of a physician, the PA will be the primary source of advice to determine the medical necessity, priority, and requirements for patient evacuation.

(6) *Authentication of medical record entries.* PAs will sign all entries they make in medical records. Inpatient treatment record documents such as histories, physicals, doctor’s orders, and narrative summaries require physician countersignature. Entries made by a PA in the HREC or the outpatient treatment record do not require a physician countersignature.

b. Inpatient duties. The attending physician is responsible for the health care delivered by the PA. A PA may assist the physician in providing inpatient care according to the following:

(1) All patients admitted to an inpatient service will have an attending physician (doctor of medicine or doctor of osteopathy).

(2) PAs may write routine orders on inpatients, using DA Form 4256 (Doctor's Orders).

(3) When required, inpatient treatment documents will be countersigned by a physician as soon as possible (as determined by local MTF commanders), but must always be countersigned within 24 hours.

(4) PAs may perform medical histories and physical examinations provided the findings are countersigned by the attending physician.

(5) Specific pre-operative counseling is the responsibility of the attending surgeon. PAs cannot perform a pre-anesthesia evaluation that requires completing an OF 522 (Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures) or DA Form 7389 (Medical Record—Anesthesia).

(6) PAs may dictate narrative summaries, but these summaries must be countersigned by the attending physician.

(7) PAs may not sign a DA Form 3647 (Inpatient Treatment Record Cover Sheet).

(8) PAs may discharge patients only on the order of the attending physician.

c. Prescriptions. Graduate PAs may be privileged to write prescriptions.

(1) These medications must have been—

(a) Reviewed and recommended by the P&T committee.

(b) Reviewed and approved by the credentials committee for use by each PA on an individual basis.

(c) Approved by the MTF commander.

(2) Each PAs PCF will contain a list of approved medications.

(3) PAs may prescribe controlled substances (note R and Q) as outlined above, and as described in treatment protocols.

(4) Each prescription signed by the PA will bear the typed, stamped, or printed statement: "May be filled at any MHSS pharmacy that recognizes the provider's privileges."

(5) When the PA is providing primary field medical support during a field training exercise or deployment, he or she may administer or prescribe any item stocked in a U.S. Army field medical set, kit, or assemblage authorized at the level of assignment.

(6) A military PAs signature block for prescription writing will be on four lines and include name, social security number (SSN), grade, the designation "USA" for a warrant officer PA, or the corps designation "SP" for a commissioned officer PA, and the title "Physician Assistant" in that order. A civilian PAs signature block will be on three lines and include name, SSN, and the title "Physician Assistant." Examples of PA signature blocks are shown in figure 3-1.

JOHN T. DOE
000-00-0000
CW3, USA
Physician Assistant

JOHN T. DOE
000-00-0000
CPT, SP
Physician Assistant

JOHN T. DOE
000-00-0000
Physician Assistant

Figure 3-1. Sample PA signature blocks

d. Medical examinations.

(1) PAs may accomplish such phases of Type A and B medical examinations as deemed appropriate by the examining physician.

(2) PAs will authenticate the physical examinations by—

(a) Signing the SF 93 in all instances when the SF 93 is required.

(b) Signing item 79 of the SF 88 with countersignature of the reviewing physician in item 80.

(c) Performing medical screening for overseas movement and signing DA Forms 4036-R (Medical and Dental Preparation for Overseas Movement).

e. Nuclear/chemical surety evaluation. PAs may perform routine periodic examinations, as required by AR 40-501, on individuals in the PRP. Following an evaluation performed by a PA, the supervising physician will countersign the SF 88 as required above. PAs are designated as qualified medical personnel to screen and evaluate individuals for the PRP, and may sign part II of DA Form 3180-R (Personnel Screening and Evaluation) according to AR 50-5 and AR 50-6.

f. Medical support to confinement or correctional facilities. PAs may—

(1) Assist in weekly preventive medicine inspections of confinement facilities.

(2) Perform medical examinations and treatment of prisoners on a daily basis.

(3) Perform the required confinement physical examinations according to AR 190-47.

g. Profiles. PAs may recommend temporary profiles not to exceed 30 days. Consecutive profiles may be recommended by PAs after consultation with a physician. The consultation must be documented.

h. Additional duties. PAs will not be used in lieu of the professional officer-of-the-day.

i. Flight duty. All PAs may assign duty limitations and recommend to an aviation unit commander, by preparing and signing a DA Form 4186 (Medical Recommendation for Flying Duty), that an aircrew member be medically restricted from aircrew duty. Only a flight surgeon (FS) may remove duty limitations on flight personnel.

3-3. Expanded roles

Trained and privileged PAs may be used in specialty areas such as aviation medicine, cardiovascular perfusion, emergency medicine, occupational health, and orthopaedics. Additions and deletions of PA specialties will be approved by the MEDCOM (MCHO-CL-L). A PA in a specialty setting may perform the initial patient workup or consultation. The patient's consultation will be reviewed and countersigned by a physician. Guidance for specific specialties is as follows:

a. Aviation medicine. A PA who successfully completes the U.S. Army Flight Surgeon Primary Course will be designated as an aeromedical PA (APA) and may be assigned to assist an FS. The APA will—

(1) Perform his or her aviation medicine duties under the supervision of a designated aviation medicine trained physician.

(2) Contribute to aviation medicine in the areas of medical examination for flying duty and primary health care for aviation personnel and their family members.

(3) Participate in the Aviation Safety Program and may supervise the fitting and use of personal safety equipment. The APA will not be a substitute for an FS in these activities.

(4) Assist in aircraft accident investigations. The APA will neither substitute for an FS in aircraft accident investigations or flying evaluation boards nor sign reports for these boards.

(5) After consultation with an FS, sign DA Form 4186 recommending an air-crewmember's return to flying duty. The name of the consulted FS will be annotated on DA Form 4186 according to AR 600-106 and on an SF 600 filed in the patient's HREC.

(6) Under the provisions of AR 600-106, be placed on noncrewmember flying status by Headquarters, Department of the Army (HQDA).

b. Cardiovascular perfusion. A PA who successfully completes an accredited cardiovascular perfusion training program may be designated as a cardiovascular perfusion PA (CVPA). When assigned perfusion duties, a CVPA will always work under the supervision of a board-eligible or board-certified cardiovascular surgeon.

c. Emergency medicine. A PA who successfully completes an accredited graduate PA emergency medicine training program may be designated as an emergency medicine PA.

d. Occupational health. A PA who receives a graduate level degree in occupational health/public health may be designated as an occupational health PA.

e. Orthopaedics. A PA who successfully completes a prescribed accredited graduate PA orthopaedic training program may be designated as an orthopaedic PA (OPA). Outpatient procedures by an OPA should not include any manipulation, minor surgery, or wound management requiring other than local or peripheral nerve block anesthesia.

3–4. PA supervisory personnel

Guidance and responsibilities for PA supervisors are outlined below.

a. General. MTF commanders will use utmost care when selecting physicians to be designated as PA supervisors. These physicians (appointed by name and in writing) must be motivated individuals with a proven ability to provide the supervision, guidance, and support needed by PAs. This supervision is of vital importance in all treatment care settings. The supervising physician must, when needed, prescribe standards of good medical practice. The supervisor must be available for consultation in person, telephonically, by radio, or available through any other communication means which allows person-to-person exchange of information. An alternate supervising physician must be available during temporary absences of the supervising physician.

b. Qualifications and duties. The physician supervisor will—

(1) Be qualified by education, training, and privileges to perform any treatment or procedure that he or she directs a PA to perform.

(2) Be responsible for a PAs medical practice and quality of care.

(3) Ensure that the PAs practice remains within the scope of the individual PAs clinical privileges.

(4) Monitor the PAs performance using established protocols and outcome criteria for treatment, referral, and follow-up care provided.

(5) Ensure that—

(a) Performance evaluations are conducted in accordance with local QI policies. These evaluations may be delayed for PAs working at geographically remote or inaccessible locations, in operationally deployed forces, or in units on field training exercises. Delayed evaluations will be conducted as soon as possible after the date on which they were due and will not usually be delayed for a period of time greater than 6 months. (The 6-month maximum delay period may be waived for deployed forces only if compliance would jeopardize the operational mission of the unit. In this case, the review will be completed at the next available opportunity.)

(b) All emergency room records are reviewed according to current QI policies.

(6) The physician supervisor will always be included as either the PAs rater or senior rater according to AR 623–105. When the supervising physician is not assigned to the same organizational element, dual supervision may exist and the commander will designate the other rating official (rater or senior rater).

Chapter 4 Physical/Occupational Therapists

4–1. Privileges

a. The credentials committee will recommend to the MTF commander those clinical privileges of assigned physical therapists (PTs)/occupational therapists (OTs) who perform the primary evaluation, diagnosis, and treatment of patients seeking care for neuromusculoskeletal disorders. MTF commanders will—

(1) Delineate in writing the scope and limits of clinical practice of these assigned PTs/OTs.

(2) Designate in writing the supervisory physician.

b. Clinical privileges should be limited to PTs/OTs who are trained to independently evaluate, diagnose, and treat specified neuromusculoskeletal disorders. PTs/OTs with additional education and training in selected subspecialty areas may be privileged to perform procedures commensurate with their documented training and/or certification. Clinical privileges are not required for PTs/OTs who do not initiate treatment without a physician's order and whose activities are limited to the scope of standard practice as defined by their license, certification, or registration.

c. Reappraisal of clinical privileges will be completed at least every 2 years and/or when the PT/OT changes station.

4–2. Expanded roles

The duties of assigned and privileged PTs and/or OTs will consist of the following:

a. General. For patients with neuromusculoskeletal complaints, PTs/OTs may be designated to perform primary evaluations according to an established protocol signed by the chief, physical therapy/occupational therapy, the chief of the appropriate supervising medical department or service, and the supervising physician at the local MTF.

b. Other expanded roles. PTs/OTs may request x rays for, and refer to the appropriate specialty clinics, those patients with neuromusculoskeletal disorders for whom they are performing primary care. The list of x ray procedures which PTs/OTs can order will be recommended by the credentials committee and approved by the MTF commander. PTs/OTs may assign those patients for whom they are performing primary care to quarters not to exceed 72 hours.

c. Profiles. PTs/OTs may authenticate temporary profiles within the parameters of their specialties except for personnel on flight status. Profiles will not exceed 30 days. Those conditions which require the extension(s) of a temporary profile beyond a total of 90 days must be authenticated by a physician.

d. Prescription writing. Privileged PTs/OTs may write prescriptions for selected medications. These medications must have been—

- (1) Recommended by the P&T committee.
- (2) Reviewed by the credentials committee.
- (3) Approved by the MTF commander.

e. Prescription statement. All prescriptions will bear the typed, stamped, or printed statement: “May be filled at any MHSS pharmacy that recognizes the provider’s privileges.”

f. Authentication of medical record entries. PTs/OTs will sign, as prescribed in AR 40–66, their medical record entries. Special documents such as histories will require physician countersignature.

g. Diagnosis and treatment limitations. PTs/OTs will not make a diagnosis or institute any treatment based on telephonic conversations with patients.

h. Other limitations. PTs/OTs are not authorized to—

- (1) Perform or sign medical examinations.
- (2) Supervise immunizations.
- (3) Administer intramuscular medications.
- (4) Conduct nuclear surety evaluations.
- (5) Substitute for physicians, PAs, or NPs in the provision of medical support to confinement and correctional facilities.

4–3. Supervisory personnel

a. General. PTs/OTs who perform the primary evaluation, diagnosis, and treatment of patients seeking care for neuromusculoskeletal complaints will have a designated physician who has oversight responsibilities for their clinical practice.

b. Designated physician. The MTF commander will appoint (by name and in writing) a supervising physician for each privileged PT/OT. An alternate supervising physician must be available during temporary absences of the supervising physician. The supervisor must be available for consultation in person or telephonically.

(1) *Qualifications and duties.* The physician supervisor will—

(a) Be a military physician. When a military physician is not available to act as supervisor in a specialty area, the MTF commander will appoint a civilian physician supervisor.

(b) Ensure that the practice of the PT/OT remains within the limits of their clinical privileges and demonstrated expertise.

(c) Ensure that PT/OTs performing in primary care areas, such as clinics and emergency rooms, refer to a physician for formal, written consultation any patient that presents the same complaint twice in a single episode of care. This does not apply to patients returning for treatment of chronic illnesses documented in their medical records.

(2) *Written evaluations.* The supervising physician will provide written evaluations addressing—

(a) Diagnostic techniques and procedures.

(b) Therapeutic practices.

(c) Patient treatment documentation based on a review of patient records. The number of records to be reviewed will be determined by the supervising physician.

(3) *Frequency of evaluations.* The supervising physician will ensure that—

(a) The evaluations are conducted periodically based on the individual’s experience and competence and according to AR 40–68. Evaluations may be delayed for PT/OTs working in geographically remote or inaccessible locations, in operationally deployed forces, or in units on field training exercises. Delayed evaluations will be conducted as soon as possible after the date on which they were due and will not usually be delayed for periods of time greater than 6 months. The 6-month maximum delay may be waived for deployed forces only if compliance would jeopardize the operational mission of the unit. In this case, the review will be completed at the next available opportunity.

(b) A copy of all documented evaluations is forwarded for review through the MTF quality assurance committee to the MTF credentials committee. (See AR 40–68 for detailed guidance on the establishment and function of the quality assurance committee.) These documents will be retained by the credentials committee and will be used in determining the renewal of clinical privileges. They will be destroyed when no longer needed.

Chapter 5 Clinical Dietitians

5–1. Privileges

a. The credentials committee will recommend to the MTF commander those extended nutritional care roles of assigned dietitians which require privileges. MTF commanders will—

- (1) Delineate in writing the scope and limits of clinical practice of these assigned dietitians.
- (2) Designate in writing the supervisory physician.

b. The nutrition care directorate/division chief will approve individual competency assessments for assigned clinical dietitians.

c. Clinical privileges will be determined upon initial assignment, upon any changes of duty assignment, and at least biennially thereafter.

d. Documentation of specialized training, work experience, education, and/or skill identifier (SI) designation in clinical dietetics must be obtained by dietitians before they provide extended nutritional care and before they obtain individual privileges. These extended services include—

- (1) Prescribing diets other than weight control, consistency modifications, or life style modification.
- (2) Independent ordering of laboratory tests.
- (3) Independent ordering of consultations from other allied health professionals (for example, social work service, community health nurse, psychiatric nurse, physical therapy, occupational therapy, speech pathologist, etc.).
- (4) Signing prescriptions for multiple vitamin supplements that provide not more than 100 to 150 percent of the Recommended Dietary Allowances (RDA) (excluding fat soluble vitamins) as a single dosage form or therapeutic nutritional supplements appearing in the MTF formulary. Vitamins will be prescribed only for patients whose diets are not meeting 100 percent of the RDAs of the National Research Council. Prescriptions will be written after coordination with the primary care physician or by preapproved protocol.

5-2. Duties

a. Assigned dietitians will—

- (1) Perform nutritional screening and assign nutritional risk.
- (2) Conduct nutritional assessments. The chief, nutrition care division will determine the level of nutritional assessment performed. Nutritional assessments include clinical examinations, anthropometric measurements, dietary histories, and laboratory tests. Clinical dietitians may—
 - (a) Perform measurements of height, weight, and specific body circumference for the estimation of body fat according to AR 600-9.
 - (b) Obtain subjective data from the patient's dietary history to determine individual nutrient intakes and tolerances.
 - (c) Order and evaluate designated routine blood, urine, and skin hypersensitivity tests.
 - (d) Prescribe certain diets (weight control, consistency modifications, life style modification).
 - (e) Recommend diet, enteral, and parenteral nutrition orders. The admitting or attending physician will order the initial diet. The dietitian may determine nutrient requirements, nutritional status, recommend appropriate feeding/nutritional support, and appropriately document the medical record.
 - (f) Recommend and refer consults to allied health care professionals.
 - (g) Implement, monitor, and record nutritional care plans.
- (3) Facilitate the Army Weight Control Program. They will provide educational classes in weight control to personnel who desire to lose weight. Unit commanders or soldiers may schedule appointments without physician referral. Follow-up may be offered by the clinical dietetics branch. The unit commander, not the dietitian, will conduct weigh-ins according to AR 600-9.
- (4) Provide nutritional education in the areas of prevention, health promotion, and medical nutrition therapy.
- (5) Order the following laboratory blood chemistry tests:
 - (a) Albumin or prealbumin.
 - (b) Glucose.
 - (c) Hemoglobin, plasma.
 - (d) Hematocrit.
 - (e) Iron-binding capacity.
 - (f) Lipids profile (triglycerides, cholesterol, high density lipoprotein cholesterol).
 - (g) Transferrin.
 - (h) White blood count or lymphocyte count.
 - (i) Urea nitrogen.
 - (j) Creatinine.
 - (k) Prothrombin times.
 - (l) HbA1C.
 - (m) Aspartate amino transferase/alanine amino transferase.
- (6) Order the following urine chemistry tests:
 - (a) Creatinine.
 - (b) Urea nitrogen.
- (7) Order other tests. Skin testing for delayed hypersensitivity may be ordered (if determined locally to be effective as part of nutritional assessment).
- (8) Prescribe therapeutic nutritional supplements.

- (9) Conduct peer review of dietitians' individual competency assessments according to the local QI program.
- (10) Prescribe vitamins as part of an approved and active protocol to which a specific patient has been enrolled or admitted.
 - b.* Dietitians are not authorized to—
 - (1) Perform or sign medical examinations.
 - (2) Supervise immunizations.
 - (3) Administer intramuscular medications.
 - (4) Conduct nuclear surety evaluations required by AR 50–5.
 - (5) Substitute for physicians, PAs, or NPs in the provision of medical support to confinement and correctional facilities.
 - (6) Assign or establish profiles.
 - (7) Make a diagnosis or institute treatment based on telephonic conversations with patients or any nonphysician HCP.
 - c.* Individually privileged clinical dietitians will have a designated physician who has oversight responsibility for their clinical practice. The designated physician supervisor will—
 - (1) Be a military physician. When a military physician is not available to act as supervisor in a specialty area, the MTF commander will appoint a civilian physician supervisor.
 - (2) Ensure that the practice of the individually privileged clinical dietitian remains within the limits of his/her privileges.
 - (3) Provide written evaluations.
 - d.* Written evaluations will address—
 - (1) Patient evaluation and procedures.
 - (2) Therapeutic practices.
 - (3) Patient treatment documentation based on a review of patient records. (The number of records to be reviewed will be determined by the supervising physician based on (1) and (2) above and the quality of the entries.)
 - e.* The supervising physician ensures that—
 - (1) The evaluations are conducted periodically based on the individual's experience and competence and according to AR 40–68. The evaluations may be delayed for clinical dietitians working at geographically remote or inaccessible locations, in operationally deployed forces, or in units on field training exercises. Delayed evaluations are conducted as soon as possible after the date on which they were due, but will never be delayed for more than 6 months. (The 6-month maximum delay may be waived for deployed forces only if compliance would jeopardize the operational mission of the unit. In this case, the review will be completed at the next available opportunity.)
 - (2) A copy of all documented evaluations is forwarded for review to the MTF credentials committee. These documents are retained by the credentials committee and used in determining renewal of clinical privileges. They will be destroyed when no longer needed.

Chapter 6

Clinical Pharmacists

6–1. Privileges

The credentials committee will, upon application by the pharmacist, recommend to the MTF commander those pharmaceutical care roles that are appropriate. The committee will consider the individual pharmacist's education and experience. Clinical privileges will be reviewed at least biennially and updated as required. Further guidance is outlined below.

a. Pharmacists wishing to be privileged in a pharmaceutical care practice field (PCPF) must have completed one of the two educational and experiential combinations described below.

(1) Eligible pharmacists include those who have completed either a 6-year Doctor of Pharmacy (Pharm D) degree program, a post-baccalaureate (MS, Pharm D, PhD) hospital pharmacy oriented degree program, or an American Society of Health-System Pharmacists accredited clinical residency training program.

(2) Registered pharmacists are eligible if they have not yet completed one of the three formal educational programs outlined in (1) above, but have demonstrated clinical competency during at least 2 years of practice in the PCPF for which they are requesting clinical privileges.

b. Limited practice privileges may be granted to a pharmacist in a PCPF while that individual is acquiring supervised patient care experience.

c. Each clinical pharmacist will develop a practice protocol consistent with his or her experience and the needs of the clinical area being supported. The protocol will be signed by the appropriate medical service or department chief

and the chief of the pharmacy service, recommended by the credentials committee, and approved by the MTF commander. Individual clinical privileges will be consistent with the general scope for that PCPF.

d. Clinical pharmacist activities will normally include taking medication histories, instructing and counseling in matters of general health maintenance and preventive health care, and conducting patient counseling concerning prescribed medications.

6–2. Expanded roles

Pharmacists working in assigned expanded roles as clinical pharmacists will be used only in those recognized PCPFs for which they have been educationally and experientially prepared. Each pharmacist will participate in peer review and patient care audits established by the specialty care service or the department they support. The operational effectiveness of clinical pharmacists will be monitored by the pharmacy service's own locally developed QI review mechanisms.

a. Clinical pharmacists may be privileged to initiate new medication orders/prescriptions for those medications deemed appropriate based on the individual's knowledge, experience, and assigned duties; adjust original medication orders/prescriptions; or renew medication orders/prescriptions.

b. All medication orders/prescriptions that are initiated, adjusted, or renewed will be based on a drug list recommended by the P&T committee, reviewed by the credentials committee, and approved by the MTF commander. All prescriptions will bear the typed, stamped, or printed statement: "May be filled at any MHSS pharmacy that recognizes the provider's privileges."

c. Clinical pharmacists may not initiate or authorize the renewal of medication orders/prescriptions for controlled substances. They may be privileged to adjust the dosage regimen of an inpatient medication order for such drugs before expiration of the original order.

d. By virtue of undergraduate education and the licensing experience requirements of the individual States, all pharmacists may dispense non-prescription medications when the MTF offers a self-care program.

e. Clinical pharmacists may be privileged to administer oral and parenteral medications, perform venipunctures, and administer intravenous fluids.

f. Clinical pharmacists will sign all entries in the medical record and outpatient prescriptions.

g. Clinical pharmacists may order tests and laboratory studies appropriate for the medications they are approved to initiate, adjust, or renew. Pharmacists who are recognized by the local credentials committee as providers of a pharmacokinetic consultation service may be privileged to initiate orders in the medical record for sample collection according to a drug kinetic study. These same individuals will write consultation notes on recommended dosage adjustment following receipt of laboratory values.

6–3. Supervisory personnel

Clinical pharmacists will be assigned to the pharmacy service of the MTF, and are responsible to the chief of that service for the quality and management of the pharmaceutical care they provide. When the pharmacist's duties dictate working within a specific specialty service (for example, hematology/oncology) the chief of that service will share in the supervisory responsibility with the pharmacy service chief.

Chapter 7 Specialty Program Providers

7–1. Family Advocacy Program personnel—social workers, social service assistants

a. Privileges.

(1) If MTF personnel believe a Family Advocacy Program (FAP) applicant does not meet DOD FAP quality assurance standards for the position, they may request that HQ, MEDCOM (MCHO–CL–H) review for approval the FAP applicant's packet (according to AR 40–1 and AR 40–68) prior to the civilian personnel office offering a job to the candidate.

(2) The credentials committee will recommend to the MTF commander individual clinical privileges of FAP personnel in Social Work Service (SWS) (or Community Mental Health (CMH) in absence of SWS). The MTF commander will ensure that the scope of clinical practice for each individual FAP social worker (SW) or social service assistant (SSA) is documented.

(3) The chief, SWS (or chief, CMH in absence of an SWS) will participate in the privileging process for FAP SWs and SSAs.

(4) Clinical privileges of FAP SWs and SSAs will be determined upon initial assignment, upon any changes of program/duty assignment, and will be reviewed according to the provisions of AR 40–68.

(5) The MEDCENs/MEDDACs privileging authority will review and recommend/grant/deny privileges to FAP

contract employees supervised by SWS (or CMH) according to procedures and standards applicable to Government personnel and according to requirements defined in the contract statement of work.

(6) FAP personnel must meet criteria of DOD defined level I or level II providers according to DOD 6400.1–M before they can be granted clinical privileges. Where licenses are required and are in process, provisional privileges may be granted up to the date of the next examination.

b. Duties and responsibilities.

(1) FAP personnel will work under the supervision of personnel as defined in DOD 6400.1–M, for the delivery of care in environments in which FAP clients may be located.

(2) FAP personnel are the primary source of care for clients involved in alleged/substantiated child/spouse abuse cases. They provide case management, counseling, therapy, educational programs, command consultation, and on-call duties.

(3) The SW will—

(a) Within the limits of training and privileges granted by the MTF commander, provide clinical intervention for offenders and victims of child/spouse abuse.

(b) Conduct intake assessments and coordinate with medical personnel, law enforcement authorities, and commanders at all levels.

(c) Develop and present a proposed treatment plan to the Case Review Committee (CRC) and provide treatment as defined by the CRC. (See AR 608–18 for composition, function and administration of the CRC.)

(d) Maintain FAP case files and forms according to prescribed policy, and complete FAP specific forms (for example, master problem list, treatment plan, etc.).

(e) Testify in court.

(f) Participate in training of professional staff.

(g) Participate with CRC in all decision making but will not make unilateral treatment decisions or referrals. The SW will document team decisions and case progress, and will not terminate treatment or close a case without CRC authorization.

(h) Review case managers' entries into case records and coordinate with case managers on client progress and collateral contacts.

(i) Serve on rotational on-call; may serve as command consultant to designated units on family issues.

(4) The SSA (case manager) will—

(a) Within the limits of training and privileges granted by the MTF commander, provide case management in instances of child/spouse abuse.

(b) Conduct initial interviews and collateral contacts, and review records to obtain information on families to make critical recommendations regarding safety and family needs. The SSA will record information according to prescribed policy and coordinate with local agencies.

c. Expanded roles. Trained and privileged SWs may be used in emergency situations beyond FAP, that is, rape response or violence in the workplace response teams. SWs with master's degrees may also be used in training MTF and installation personnel on the dynamics of violence and characteristics of violent personalities.

d. Supervisory personnel. The delivery of FAP services will be accomplished under supervision of privileged personnel according to DOD 6400.1–M, chapter 7.

7–2. Early intervention specialists

a. General.

(1) The early intervention (EI) specialist must implement a comprehensive program of services for developmentally delayed infants and toddlers from birth through 36 months of age who would, but for their age, be eligible for enrollment in DOD schools. Services may include, but not be limited to, OT, PT, speech and language pathology, early childhood special education, counseling for families, and referral services.

(2) Professional staff must hold credentials appropriate to the discipline and service they provide.

b. Privileges.

(1) The credentials committee will recommend to the MTF commander those EI services that the applicant may provide. The commander will ensure documentation of the duties, responsibilities, and scope of clinical practice for each EI specialist.

(2) The early childhood special educator must have completed master's level training. Academic training for other professional staff must prepare them for working with infants and toddlers.

c. Expanded roles. The duties of the EI specialists are outlined below.

(1) *Duties.* Services provided by the EI specialists will directly or indirectly facilitate infant and toddler development. EI treatment services include procedures and equipment which enhance the child's ability to participate in activities of daily living and prepare the child for participating in a learning experience. EI medical procedures are for diagnostic purposes to determine eligibility for EI or to consider changes in EI services. Services are provided

according to an Individualized Family Service Plan and in the child's natural setting. EI services generally fall into three broad categories: service coordination, screening and evaluations, or treatment.

(2) *Limitations of services.* EI services do not include medical procedures which would be provided as part of pediatric care for typical children.

d. *Supervisory personnel.* All EI services are provided under the medical supervision of a physician.

7-3. Alcohol and Drug Abuse Prevention and Control Program clinical directors and counselors

Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) counselor appointments or placements (to include clinical director) are subject to prior approval by an addiction medicine specialist in the responsible Health Service Support Area. Forwarded recommendations will be accompanied by the completed preemployment verification package. (See AR 690-300.) All counselors and clinical directors must be in GS 185/180 job series. These positions have a selection placement factor that requires State or national certification in alcohol and drug abuse. According to AR 600-85, urine samples must be provided, as required. In addition to new hires, preemployment verification procedures also apply to transfers from other agencies, assignments within Army, Priority Placement Program placements, and any other situation where personnel are assigned clinical ADAPCP duties. If the pre-employment verification process was previously completed, then it need not be reinitiated. In these cases, a statement to this effect signed by the commander, or his or her designee, of the gaining MTF, will accompany the documents submitted to higher headquarters for review and approval.

a. Privileges.

(1) The ADAPCP clinical director (CD) may be a GS-180 or 185 occupational series employee (at the GS-12 or -13 grade level). The CD must be privileged at level 3 or level 4 by the MTF and approved by the MEDCOM (MCHO-CL-H) before assuming CD responsibilities. Before a job offer is made, the application packet of the potential ADAPCP CD will be reviewed by the local MTF credentials committee to determine whether the individual can be privileged at level 3 or 4. If the pre-privileging review indicates that the applicant can be privileged at level 3 or 4, the packet is so notated. The packet is then sent to the MEDCOM (MCHO-CL-H) for final review and approval.

(2) The CD must also hold advanced substance abuse certification from a State or nationally accredited certifying body, or be licensed as an SW, psychologist, or professional counselor.

(3) Clinical privileges will be reviewed according to the provisions of AR 40-68 and the medical staff standards in the current Joint Commission on Accreditation of Healthcare Organizations "Accreditation Manual for Hospitals."

(4) The ADAPCP counselors may be GS-180 or -185 series with entry level grade 9. Generally, they are not individually privileged by the hospital; rather, they work under the supervision and privileges of the CD.

(5) The ADAPCP CD will document the individualized scope of practice for each counselor based upon the counselor's education, training, and experience. The clinical consultant or deputy commander for clinical services (DCCS) will ensure that the CD delineates each counselor's scope of practice before the counselor assumes a case load. Each counselor's scope of practice will be reviewed annually and modified, if appropriate, as the counselor completes additional educational/training experiences.

b. Duties and responsibilities.

(1) The ADAPCP CD serves as the clinical manager/administrator and chief clinician for all ADAPCP screening and rehabilitative services. The CD is supervised by the physician clinical consultant or by the DCCS.

(2) The ADAPCP counselors, under the supervision of the CD, provide screening and rehabilitative services, according to their scope of practice outlined by the CD and approved by the clinical consultant. The ADAPCP counselors also conduct command consultation and provide technical assistance in the installation's ADAPCP preventive/educational endeavor.

7-4. Professional staff in Exceptional Family Member Program medical clinics

a. General.

(1) Professional staff assigned to perform Exceptional Family Member Program (EFMP) medical functions will fulfill the requirements of AR 608-75.

(2) The EFMP professional staff provide evaluations, developmental assessments, medically-related services in support of DOD Dependents Schools outside the continental United States (OCONUS), and clinical services to children from birth to age 21.

(3) Professional staff must hold academic degree(s), certifications, and licenses appropriate to their specific discipline. Non-physician disciplines comprising EFMP medical clinic staffs include—

- (a) Pediatric occupational therapy.
- (b) Pediatric physical therapy.
- (c) Speech/language pathology.
- (d) Audiology.
- (e) Clinical child psychology.
- (f) Clinical social work.

(g) Community health nursing.

b. Privileges.

(1) Providers in the EFMP operate as members of a multidisciplinary team and are hired and privileged to function as experts in their specialty as it applies to a pediatric and special education population.

(2) All EFMP professional staff must have documented evidence of training and/or experience in providing services to special-needs children from birth to age 21.

c. Expanded roles.

(1) In the continental United States, EFMP multidisciplinary clinics are located at MEDCENs within the department of pediatrics. These clinics provide EFMP support to all the MTFs in their respective Health Service Support Area. In addition to providing direct clinical services, EFMP clinicians also participate as members of the EFMP coding team. The coding team is responsible for reviewing, verifying and assuring consistency of the medical and special education information submitted on active duty family members for enrollment in the EFMP.

(2) In OCONUS locations, EFMP medical clinics are independent units reporting directly to the MTF DCCS. The primary mission of these clinics is to provide evaluations and medically related services in support of special educational requirements of DOD Dependents Schools.

(3) The OCONUS EFMP clinics also provide pediatric sub-specialty support to other clinics within their MTF.

d. Supervisory personnel. All EFMP medical and medically-related services are provided under the supervision of a designated EFMP medical director. AR 608-75 requires that every MTF commander identify a physician to serve as the MTF's EFMP medical director.

Appendix A

References

Section I

Required Publications

AR 40-1

Composition, Mission, and Functions of the Army Medical Department. (Cited in para 7-1a(1).)

AR 40-2

Army Medical Facilities: General Administration. (Cited in para 2-2a.)

AR 40-66

Medical Record Administration. (Cited in paras 2-2i and 4-2f.)

AR 40-68

Quality Assurance Administration. (Cited in paras 2-1, 2-3c(3)(a), 2-3c(3)(c), 4-3b(3)(a), 4-3b(3)(b), 5-2e(1), 7-1a(1), 7-1a(4), and 7-3a(3).)

AR 40-407

Nursing Records and Reports. (Cited in para 2-2i.)

AR 40-501

Standards of Medical Fitness. (Cited in paras 2-2g and 3-2e.)

AR 50-5

Nuclear and Chemical Weapons and Materiel—Nuclear Surety. (Cited in paras 2-2e, 3-2e, and 5-2b(4).)

AR 50-6

Nuclear and Chemical Weapons and Materiel—Chemical Surety. (Cited in para 3-2e.)

AR 190-47

The Army Corrections System. (Cited in paras 2-2f(2) and 3-2f(3).)

AR 600-9

The Army Weight Control Program. (Cited in paras 5-2a(2)(a) and 5-2a(3).)

AR 600-85

Alcohol and Drug Abuse Prevention and Control Program. (Cited in para 7-3.)

AR 600-106

Flying Status for Nonrated Army Aviation Personnel. (Cited in paras 3-3a(5) and 3-3a(6).)

AR 608-18

The Army Family Advocacy Program. (Cited in para 7-1b(3)(c).)

AR 608-75

Exceptional Family Member Program. (Cited in paras 7-4a(1) and 7-4d.)

AR 623-105

Officer Evaluation Reporting System. (Cited in para 3-4b(6).)

AR 690-300

Civilian Personnel Employment. (Cited in para 7-3.)

DOD 6400.1-M

Family Advocacy Program Standards and Self Assessment Tool. (Cited in paras 7-1a(6), 7-1b(1), and 7-1d.) (This manual may be ordered from the Naval Publications and Forms Center, 5801 Tabor Avenue, Philadelphia, PA 19120-5099.)

Joint Commission on Accreditation of Healthcare Organizations

Accreditation Manual for Hospitals. (Cited in para 7–3a(3).) (This manual may be obtained from the Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Boulevard, Oakbrook Terrace, IL 60181.)

Section II Related Publications

Joint Commission on Accreditation of Healthcare Organizations publications

Mental Health Manual
Long-Term Care Manual
Home Care Manual
Ambulatory Care Manual
Pathology and Clinical Laboratory Manual
Health Care Networks Manual

(Copies of these manuals can be obtained from the Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Boulevard, Oakbrook Terrace, IL 60181.)

Section III Prescribed Forms

This section contains no entries.

Section IV Referenced Forms

DA Form 67–9
Officer Evaluation Report

DA Form 3180–R
Personnel Screening and Evaluation

DA Form 3647
Inpatient Treatment Record Cover Sheet

DA Form 4036–R
Medical and Dental Preparation for Overseas Movement

DA Form 4186
Medical Recommendation for Flying Duty

DA Form 4256
Doctor's Orders

DA Form 5374–R
Performance Assessment

DA Form 5441–R series
Evaluation of Privileges—(Specialty)

DA Form 7389
Medical Record—Anesthesia

OF 522
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures

SF 88
Report of Medical Examination

SF 93
Report of Medical History

SF 513
Medical Record—Consultation Sheet

SF 600
Health Record—Chronological Record of Medical Care

Glossary

Section I Abbreviations

ADAPCP

Alcohol and Drug Abuse Prevention and Control Program

AN

Army Nurse Corps

APA

aeromedical physician assistant

ASA

American Society of Anesthesiologists

CD

clinical director

CHN

community health nurse

CMH

Community Mental Health

CN

chief nurse

CNM

certified nurse midwife

CPG

clinical practice guideline

CRC

Case Review Committee

CRNA

certified registered nurse anesthetist

CVPA

cardiovascular perfusion physician assistant

DCCS

deputy commander for clinical services

DOD

Department of Defense

EFMP

Exceptional Family Member Program

EI

early intervention

FAP

Family Advocacy Program

FS

flight surgeon

HCP

health care provider

HQDA

Headquarters, Department of the Army

HREC

health record

MEDCEN

U.S. Army Medical Center

MEDCOM

U.S. Army Medical Command

MEDDAC

U.S. Army Medical Department Activity

MHSS

military health services system

MTF

medical treatment facility

NCCPA

National Commission on Certification of Physician Assistants

NP

nurse practitioner

OB/GYN

obstetrical/gynecological

OCONUS

outside continental United States

OPA

orthopaedic physician assistant

OT

occupational therapist

PA

physician assistant

PCF

practitioner credentials file

PCPF

pharmaceutical care practice field

PRP

Personnel Reliability Program

PT

physical therapist

P&T

pharmacy and therapeutics

QI

quality improvement

RDA

Recommended Dietary Allowances

SI

skill identifier

SSA

social service assistant

SSN

social security number

SW

social worker

SWS

Social Work Service

TOE

table of organization and equipment

TSG

The Surgeon General

Section II**Terms****ADAPCP clinical director**

Manager of the ADAPCP clinic, qualified at the GS-12 grade in the 180 or 185 series and privileged by U.S. Army Medical Centers or U.S. Army Medical Department Activities at level 3 or 4.

ASA categories I–V

(Same as ASA physical status classification system P1–P5.)

Note. The “P” before each classification number refers to “physical status.”

P1—A normal healthy patient.

P2—A patient with mild systemic disease.

P3—A patient with severe systemic disease.

P4—A patient with severe systemic disease that is a constant threat to life.

P5—A moribund patient who is not expected to survive without the operation.

Certified registered nurse anesthetist

A registered nurse who has graduated from an approved program in nursing anesthesia, accredited by the American Association of Nurse Anesthetists Council on Accreditation and who is certified as a registered nurse anesthetist by the Association’s Council on Certification. AN officers who are CRNAs are in Area of Concentration 66F.

Certified nurse midwife

A registered nurse who has successfully completed a master’s degree program accredited by the American College of Nurse–Midwives and who is certified in nurse midwifery by the American College of Nurse Midwives. AN officers who are certified nurse-midwives hold the 8D (nurse midwife) skill identifier (SI).

Clinical dietitian

A registered dietitian who, by virtue of education and experience, has completed a post baccalaureate degree in nutrition or related subjects, thus enabling him/her to evaluate, diagnose, and treat patients at nutritional risk.

Clinical nurse specialist

A registered nurse who has graduated from a National League for Nursing accredited master’s program in nursing, with emphasis in a clinical nursing specialty. Examples of clinical nursing specialties include, but are not limited to,

psychiatric, medical–surgical, critical care, and oncology nursing specialties. The clinical nurse specialist provides direct and indirect (integrating/coordinating) nursing care; conducts and utilizes nursing research; teaches staff, patients, and families; and serves as consultant in clinical nursing practice. AN officers who are clinical nurse specialists are designated with the 7T SI.

Clinical pharmacist

A pharmacist who, by virtue of education or experience, has been prepared to perform in the expanded role of pharmaceutical care.

Community health nurse

A registered nurse who has successfully completed a post baccalaureate program of study (for example, Principles of Military Preventive Medicine 6A–F5) which prepares the registered nurse to provide family–centered nursing services to individuals, families, and groups in the community which include epidemiological and health promotion support.

Credentials Committee

A committee that evaluates the professional competence of all individuals for the assignment or curtailment of clinical privileges.

Early intervention specialist

A professional staff member (for example, early childhood special educator, pediatric occupational/physical therapist, pediatric speech therapist/pathologist, social worker/family therapist, maternal and child health nurse/community health nurse/pediatric nurse practitioner, developmental pediatrician) who provides cognitive, physical, communicative, social/emotional, and adaptive development services to infants and toddlers with developmental delay or high probability of delay.

Expanded roles

Refers to providers having advanced training and experience to perform functions beyond the normal scope of practice.

Nonphysician health care providers

Military or civilian personnel, other than doctors of medicine or osteopathy, who are authorized and responsible for determining, starting, or altering the regimen of medical treatment provided to a patient whether on a routine or occasional basis.

Note R and Q items

Those items designated by the Controlled Substance Act of 1970 as Schedule II substances and certain other items that have been determined to merit control are listed as Note R items. Those items designated as Schedule II, IV, and V substances are listed as Note Q items.

Nurse practitioner

A registered nurse who has graduated from a post baccalaureate nursing program of study accredited by the National League for Nursing, prepared to perform primary care services for ambulatory patients and educational services for specified inpatients. The NP is further defined within any one of the pediatric, OB/GYN, adult ambulatory care, and family NP specialties.

Occupational therapist

Selected occupational therapists who have completed an approved advanced course in upper extremity evaluation and treatment, to include approved direct supervision by an orthopaedist; have been awarded the upper extremity musculoskeletal evaluation 7H SI; and have been designated to function as nonphysician HCPs under the direct supervision of a physician.

Physical therapist

Designated physical therapists who have advanced education, special qualifications, and experience that enables them to evaluate, diagnose, and treat patients with neuromusculoskeletal complaints, have been awarded the 8G SI, and have been designated to provide primary care as a nonphysician HCP under the supervision of a specified physician.

Physician assistant

A graduate from an approved physician assistant training program or has current NCCPA certification who can provide patient evaluation, diagnosis, treatment, and other services under the supervision of a physician.

Privileging

The processing through credentials committee channels of those individuals given the authority and responsibility for making independent decisions to diagnose, initiate, alter, or terminate a regimen of medical or dental care.

Social worker

Practitioner has a master of social work/doctorate of social work/doctorate in philosophy from a university accredited by the Council on Social Work Education. Provides full range of social work services as qualified by education and training. Acts independently in providing patient care.

Social service assistant

Assists in the performance of social case work and other services and works under the direct supervision of a privileged master of social work/doctorate of social work/doctorate of philosophy.

Specialty program providers

For purposes of this regulation, includes FAP social workers and social work assistants, professional staff in EI services, ADAPCP clinical directors and counselors, and professional staff in EFMP medical clinics.

Supervising physician

A specifically designated physician responsible for professional supervision of designated nonphysician HCPs.

Section III**Special Abbreviations and Terms**

This section has no entries.

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